MEDICAL ADVICE SCHEDULE

|  |  |
| --- | --- |
| Employee Name: |  |
| Email Address: |  |

|  |  |
| --- | --- |
| Doctors Name: |  |
| Phone no: |  |
| Address: |  |
| Medical Conditions: |  |
| Allergic Reactions: |  |
| First Aid Treatment: |  |
| Medication Carried:  (Instructions for use) |  |

NEXT OF KIN: (In case of emergency)

|  |  |  |
| --- | --- | --- |
| Name: |  | |
| Address: |  | |
| Contact number: | Daytime: | Mobile: |